

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3), then please remove carbon copies. Pages 1 and 2 should be filed in the funeral director's office for 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8608264					
1. DECEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR							
<i>Clara</i>			<i>Margaret</i>	<i>GESSNER</i>	<i>3 - 27 - 86</i>					<i>7:15 p.m.</i>							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR							
Female		White		MONTH	DAY	YEAR	77	YRS	MONTHS DAYS		IF UNDER 24 HRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH							
Maryland		U.S.A.					Caroline			Denton							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>Caroline NURSING HOME</i>												Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
13b. STATE	13b. COUNTY	13c. CITY OR TOWN				Caroline Apts. 21629											
Maryland	Caroline	Denton															
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			Margaret C. Leimbach			ADDRESS							
Herman L. Sehnke										Stevensville, MD							
16a. WAS DECESSED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		220-14-2121					<i>CARCINOMATOSIS</i>			<i>6 mos</i>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)																	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>PRIMARY CANCER UNKNOWN SITE</i>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c)																	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE									
22a. I certify that (1) this hospital attended the deceased from 3/12/86 to 3/19/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) I did not view the body after death.																	
22b. SIGNATURE <i>Christian E. Jensen MD</i>		22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>3/27/86</i>									
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Christian E. JENSEN MD</i>		22g. ADDRESS <i>P.O. Box 690, Denton MD 21629</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 03-30-86		23c. NAME OF CEMETERY OR CREMATORIAL SECURITY PROCESS, INC.			23d. LOCATION CITY OR TOWN Baltimore County			STATE MD							
24. FUNERAL DIRECTOR NAME Tom Helfenben Funeral Home, Chester, MD 21619		ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 02 1986			25b. REGISTRAR'S SIGNATURE <i>Jane Anderson-Pender</i>									
DHMH - 16 60M 7/84 (VRA 15, 4)																	

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28.2 ~~WATER SUPPLY AND DRAINAGE~~

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WATER SUPPLY AND DRAINAGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be detached for use as the burial/transit permit. Then please send a copy of this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-00839

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 8 2 6 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR				
Bessie Mary Grant				March 11 1986				7 AM							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		Cau.		4-28-21			64		YRS.		MONTHS DAYS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Caroline		MD.						
10 CITY OR TOWN OF DEATH Greensboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maple Village		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b KIND OF BUSINESS OR INDUSTRY none								
13a STATE Md.		13b COUNTY Caroline		13c. CITY OR TOWN Greensboro			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Maple Village		21639				
14 FATHER'S NAME FIRST Harry Whittaker		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST Unknown		MIDDLE		LAST				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) 572-22-0707		17 INFORMANT Samuel A. Iacona, Sr. Greensboro, Md.			ADDRESS				APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) 															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
YES <input type="checkbox"/> NO <input type="checkbox"/>							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/11/86 , 19 86 , to 3/11/86 , 19 86 , that (I) (we) last saw the deceased alive on 3/11/86 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (will) did (not) view the body after death.															
22b. SIGNATURE Ronald J. Sanchez MD		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3/11/86							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald J. Sanchez MD		22f. ADDRESS 323 Commerce Dr. #100 Fenton, MD 20761													
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 3-11-86		23c NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d LOCATION CITY OR TOWN Lewes		COUNTY Sussex		STATE Del.				
24 FUNERAL DIRECTOR NAME John E. Boulais		ADDRESS Greensboro, Md. 21639			25a. DATE REC'D. BY REGISTRAR MAR 17 1986		25b. REGISTRAR'S SIGNATURE Jeanne Seiden-Rosen								



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00-00141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to funeral cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										6	0	8	2	6	6
										REG. NO. 608266					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
Sherman E. Hignutt						March 8, 1986			12:45 P						
3. SEX Male			4 RACE Cau.			5. DATE OF BIRTH MONTH DAY YEAR July 2 1889			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 96 YRS.						
7a. BIRTHPLACE COUNTRY Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.						
10. CITY OR TOWN OF DEATH Denton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10 S. 7th St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant			12b. KIND OF BUSINESS OR INDUSTRY Electric Co.						
13a. STATE Md.			13b. COUNTY Caroline			13c. CITY OR TOWN Denton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 10 S. 7th St. 21629			
14. FATHER'S NAME FIRST MIDDLE LAST Otis M. Hignutt						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie L. Andrews									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-10-0649			17. INFORMANT ADDRESS Iris N. Hignutt Denton, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE PROSTATE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2.5 yrs.					
DUE TO, OR AS A CONSEQUENCE OF { (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										73 MAR 8 1986					
22b. SIGNATURE Christian E. Jensen MD. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED 3/8/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTIAN E. JENSEN MD.			22e. ADDRESS P.O. Box 690, Denton MD 21629												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3-9-86			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes COUNTY Sussex STATE Del.						
24. FUNERAL DIRECTOR NAME John E. Boulais			ADDRESS Greensboro, Md.			25a. DATE REC'D. BY REGISTRAR MAR 13 1986			25b. REGISTRAR'S SIGNATURE John E. Boulais - Rendell						
DHMH - 16 50M 4/82 (VRA 15, 4)															

920-21

WATER STATE OF THE MACHINERY

100% 80% 60% 40% 20% 0%
Water level

0% 20% 40% 60% 80% 100%

3/23 11:00 AM X 100% 80% 60% 40% 20% 0%
Gauge reading
Cylinder pressure

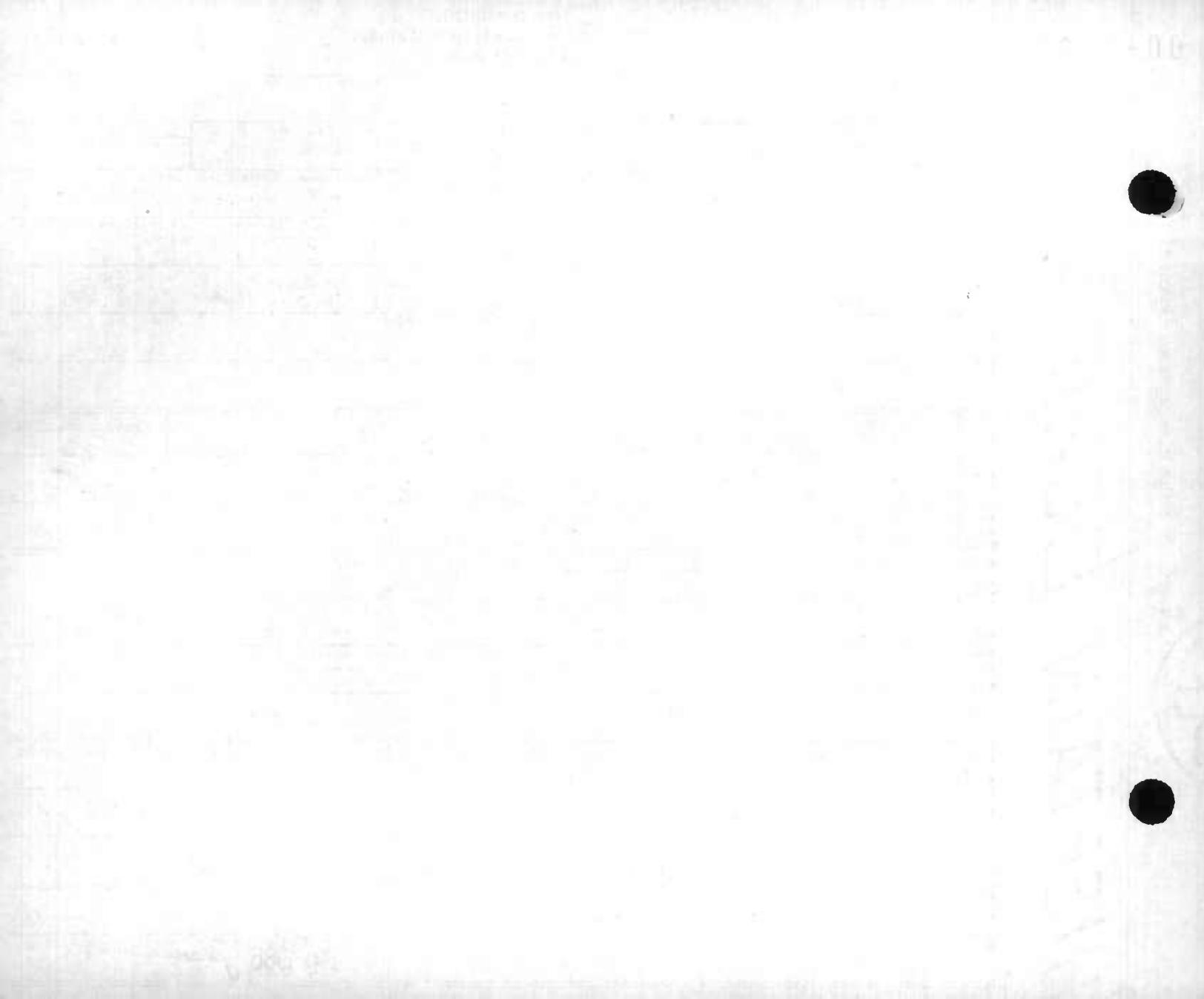
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medicoregistrar must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										6 0 8 2 6 7			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
ANNIE			J.		HURT	3 14 86						M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH 12 DAY 28 YEAR 12			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
FEMALE		BLACK		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH 1823 CAROLINE ST. 21213 MD.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? US		8.									
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHN HOPKINS HOSPITAL			12a. USUAL OCCUPATION BEAUTICIAN			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1823 N. Caroline St. 21213					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Chart		ADDRESS							
NO													
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive heart failure 16yr Pneumonia 2yr Hypertension 3yr											
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a.		19b.						20a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, CARET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 2/15/86 to 2/28/86, that (I) (we) last saw the deceased alive on 2/26/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE M. Zimring MD		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3/1/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Zimring, MD		22e. ADDRESS Mercy Hosp											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-19-86		23c. NAME OF CEMETERY OR CREMATORIAL ARBUITUS MEM. PK.			23d. LOCATION CITY OR TOWN Baltimore		COUNTY Maryland		STATE		
24. FUNERAL DIRECTOR NAME E.L. Phillips		ADDRESS 1721-21 N. MONROE ST.			25a. DATE REC'D. BY REGISTRAR MAR 19 1986			25b. REGISTRAR'S SIGNATURE John [Signature]					



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the program, although it is not mentioned in the document. However, the document does mention the "affordable" nature of the program.

SECRET // Sensitive

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and transmitted in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 08269					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 3-13-86									2b. HOUR M					
I. DECEASED NAME (TYPE OR PRINT)			FIRST Hubert	MIDDLE S.	LAST Nichols	5. DATE OF BIRTH MONTH 12 DAY 27 YEAR 1916			6. AGE (IN YEARS LAST BIRTHDAY) 69			IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.					
3. SEX Male			4. RACE White			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Caroline					
10. CITY OR TOWN OF DEATH Federalsburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 304 W. Central Avenue									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Broker			12b. KIND OF BUSINESS OR INDUSTRY Real Es. M		
13a. STATE Maryland			13b. COUNTY Caroline			11c. CITY OR TOWN Federalsburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. FATHER'S NAME FIRST Robert MIDDLE S. LAST Nichols			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE F. LAST Mowbray		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW 11 215-05-1432			17. INFORMANT Mrs. Margaret Nichols			ADDRESS 21632 Fed., Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 mo					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u> , <u>Renal failure</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>11 Sep 1972</u> to <u>13 Mac 1986</u> , that (I) (we) last saw the deceased alive on <u>1-23-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												22c. DATE SIGNED 3/15/86					
22b. SIGNATURE <u>Sgt. Clegg</u>			22d. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-16-86			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery			23d. LOCATION CITY OR TOWN Fed., Caroline, Md.			COUNTY STATE					
24. FUNERAL DIRECTOR Williamson Funeral Home ADD'L Fed., Md. 21632												25a. DATE REC'D. BY REGISTRAR MAR 26 1986			25b. REGISTRAR'S SIGNATURE Julie L. Darden-Pendell		

100-10-00

00000000

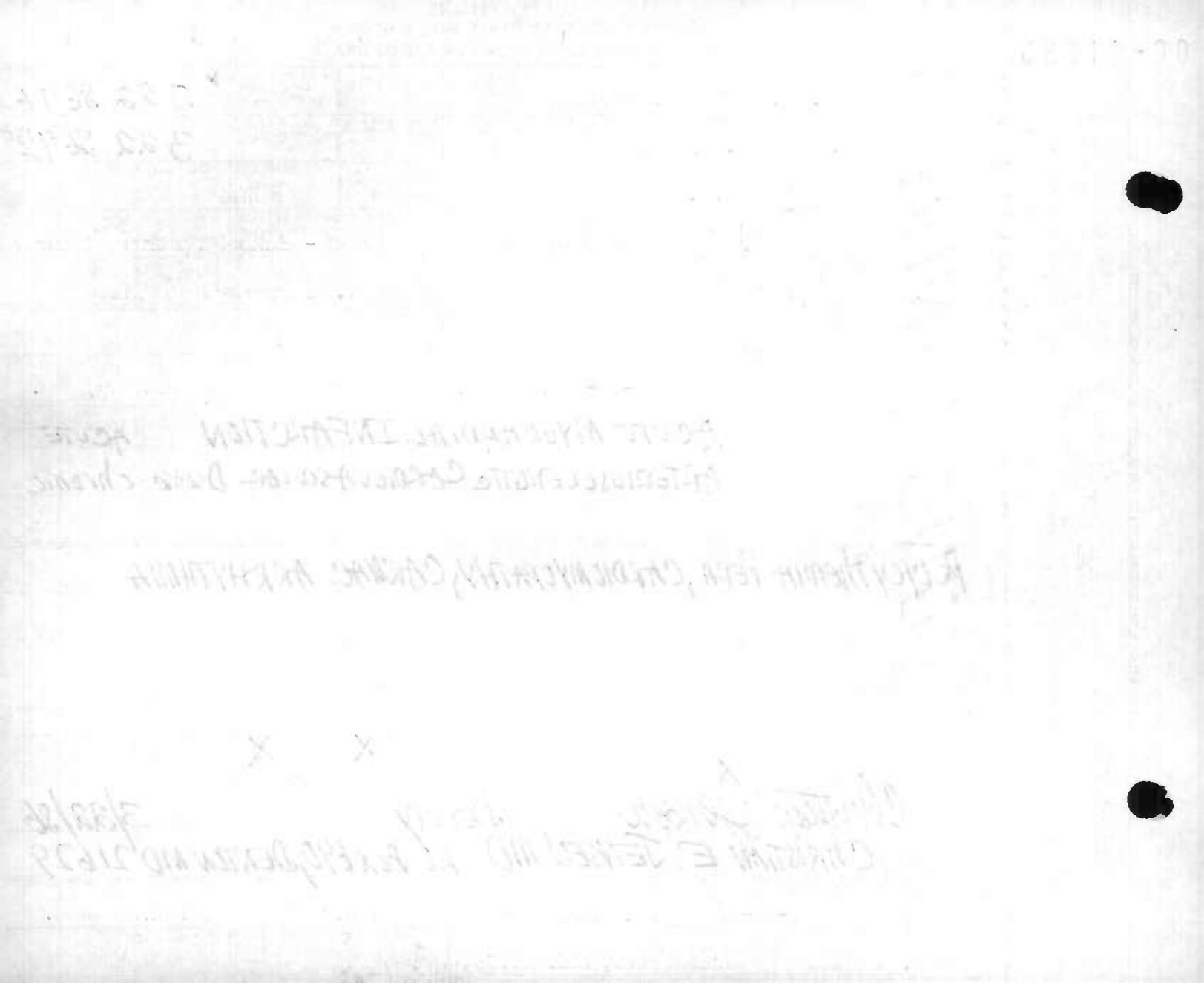
00-01536

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												08270
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
Sr. M. Julia Ruskowski						<input type="checkbox"/>			3	22	1986	7A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9c. DATE PRONOUNCED DEAD	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Female	Cau.	Dec. 7, 1912	73 yrs.	MONTHS	DAYS	HOURS	MIN.	Ridgely	St. Gertrude's Infirmary	Nun - School Teacher	Church	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. STREET ADDRESS									
Del.	U.S.A.	<input checked="" type="checkbox"/>	St. Gertrude's									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY									
Ridgely	St. Gertrude's Infirmary	Nun - School Teacher	Church									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS								
Md.	Caroline	Ridgely	<input checked="" type="checkbox"/>	St. Gertrude's								
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST							
Anthony	Ruskowski		Julia	Mroczyński								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS									
no	221-44-7983	St. Gertrude's Priory	Ridgely, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (o) ACUTE MYOCARDIAL INFARCTION			ACUTE									
DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												
(b) ARTERIOSCLEROTIC CARDIOVASCULAR Disease			chronic									
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 POLYCYTHEMIA VERA, CARDIOMYOPATHY, CARDIAC ARRHYTHMIA												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <i>Christian E. Jensen</i> TITLE (SPECIFY) <i>M.D.</i> MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT) <i>CHRISTIAN E. JENSEN MD</i> ADDRESS <i>P.O. Box 690, Denton MD 21629</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 3-26-86	23c. NAME OF CEMETERY OR CREMATORIAL St. Gertrude's	23d. LOCATION CITY OR TOWN Ridgely	23e. COUNTY Caroline	23f. STATE Md.							
24. FUNERAL DIRECTOR NAME John E. Boulais	ADDRESS Greensboro, Md. 21639	25a. DATE REC'D. BY REGISTRAR MAR 27 1986	25b. REGISTRAR'S SIGNATURE <i>Juli Frideres Pendell</i>									
DHMH-17 (VR A15 ME (5)) 15M 2/80												



071072

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 6 0 8 2 7 1

1. DECEASED NAME (TYPE OR PRINT)				FIRST Mary	MIDDLE Josephine	LAST Sharp	2a. DATE OF DEATH MONTH Mar	DAY 2, 1986	YEAR	2b. HOUR 9 A.M.
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH Jan		DAY 1, 1920	6. AGE (IN YEARS LAST BIRTHDAY) 66		IF UNDER 1 YEAR MONTHS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Caroline		MD.	
10. CITY OR TOWN OF DEATH Denton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCHEEDED, GIVE STREET ADDRESS) Hobbs Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) salesperson		12b. KIND OF BUSINESS OR INDUSTRY Avon				
13a. STATE Md		13b. COUNTY Caroline		13c. CITY OR TOWN Denton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> *		13e. STREET ADDRESS Hobbs Rd. 21629		
14. FATHER'S NAME FIRST Alva		MIDDLE Hubbard	LAST	15. MOTHER'S MAIDEN NAME FIRST Hattie		MIDDLE	LAST Maloney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220033938A		17. INFORMANT John Sharp, Denton, Md.		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION, HYPERCHOLESTEROLEMIA ACUTE										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ACUTE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) show the deceased live on above (b) did not view the body after death 2123 19 86						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2123 19 86 to 73 311 19 86 , that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (I) did not view the body after death										
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Christian E. Jensen MD		22c. DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3/2/86						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 5, 86		23c. NAME OF CEMETERY OR CREMATORIAL Concord		23d. LOCATION CITY OR TOWN Denton		COUNTY Caroline	STATE Md.	
24. FUNERAL HOME NAME Moore Funeral Home, Denton, Md.		25a. DATE REC'D. BY REGISTRAR MAR 05 1986		25b. REGISTRATION NO. JULIA LINDA RENDLE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked and item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL ALONG WITH FORM PA 3. RETAIN PAGE 1 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES PA 3 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL Cremation, or Removal.

MEDICAL CERTIFICATION

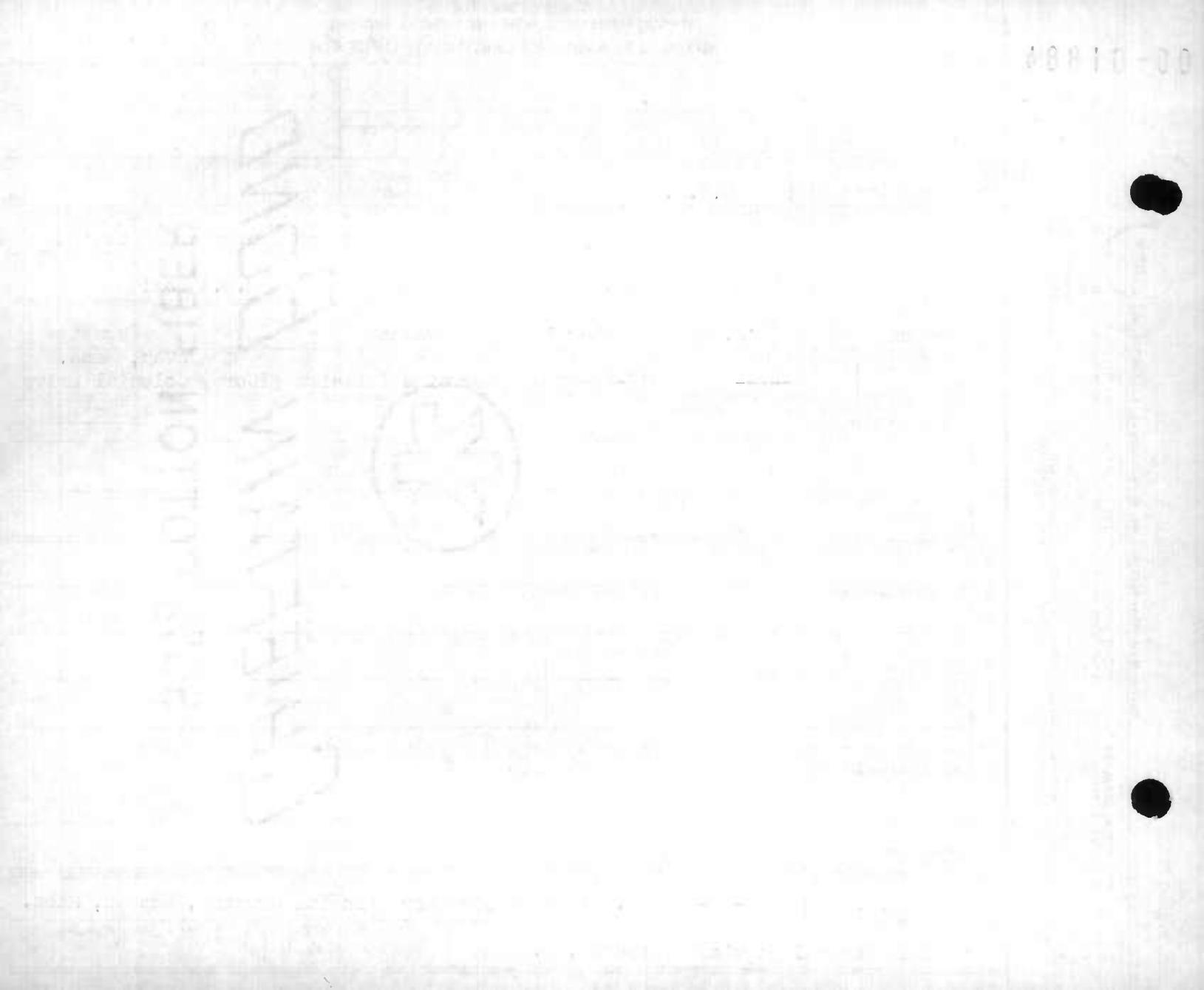
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08272
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
Peter			N.		Therrien	<input checked="" type="checkbox"/>	3	24	1986	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	White	6 17 1935 50 yrs.			3	24	1986	9PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Massachusetts		U.S.A.				Caroline County				
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Preston		Todd's Wharf Road				Custom Couturier			Fashion	
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS R.D.1 Box 189		21655	
14. FATHER'S NAME FIRST Arthur		MIDDLE J.	LAST Therrien	15. MOTHER'S MAIDEN NAME FIRST Ermena		MIDDLE		LAST Vermette		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. ----		17. INFORMANT		ADDRESS		Agawam, Mass.		
		012-26-9886		Lorraine Teixeira		51 Corey Colonial Drive				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on _____ Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE _____ M.D. Assistant MEDICAL EXAMINER										
DATE SIGNED 3/25/86										
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. kauffman, M.D. ADDRESS 111 Penn St. Balto. MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 3-29-86		23c. NAME OF CEMETERY OR CREMATORIUM St. Aloysius Cemetery		23d. LOCATION CITY OR TOWN Indian Orchard, Hampden, Mass.				
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service		ADDRESS Upperco, Md.		25a. DATE REC'D. BY REGISTRAR MAR 27 1986		25b. REGISTRAR'S SIGNATURE				
07/84 BP DHMH - 17 (VR A15 ME (5))										

48810-00



VOID

CERT. # 86-08273

1960-1961

00-015381- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 6 0 8 2 7 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Lelia N. Willis						03	18	86	2:22 A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		C		July 6, 1895		90		YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Federalsburg, Md.		U.S.A.				Caroline					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Denton		Wesleyan Health Care Center		Housewife		Own Home					
13a. USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE	13b. COUNTY	13c. CITY, OR TOWN	13e. STREET ADDRESS / ZIP CODE								
MD	Caroline	Federalsburg	RFD 2 Box 350 21632								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Purnell W. Towers			Mary Virginia Todd								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
ND			213-74-6751			J. Robert Willis, 416 August St., Easton,			Maryland 21601		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>						5					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE PNEUMONIA</u>						1 DAY					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED <small>AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/31/86</u> , 19_____, to <u>3/18</u> , 19_____, that (I) (we) last saw the deceased alive on <u>19_____</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Bruce M. Grun</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Bruce M. Grun</u>						22e. ADDRESS Box 122, GOLDSBORO, MD 21636					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		22c. DATE SIGNED <u>3/19/86</u>			
Burial		Mar. 20, 1986		Hillcrest Cemetery		Federalburg, Caroline, Md.					
24. FUNERAL DIRECTOR NAME <u>Hampton-Hawkins Box 43 Federalsburg, Md 21632</u>						25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <u>Mar 26 1986</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please return carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is checked or Item 18 shows any injury or other traumatic event, the medical examiner must be informed and a certificate issued.

00010-00

see me whenever

see you

this business

not to do again. I will see you

not always you

you

you are

you

you should never let us go

you

00-01539

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for view on the burial permit. Then please remove carbon paper. Page 3 will be held with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. Cremation prior to burial must be done with the State Dept. of Health and Mental Hygiene prior to removal of body from the hospital or attending physician's office.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be called or advised.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												6 0 8 2 7 5			
												REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
			DOROTHY DAUBERT			WISE			March 14, 1986			9:40 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Caucasian		Feb 21, 1912			74 YRS.			MONTHS		DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		U.S.A.					Caroline								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Denton		402 Fountain Avenue			Housewife			Home							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland		Caroline		Denton						402 Fountain Ave. 21629					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Werner		Sauer			Katherine			Daubert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220229405			17. INFORMANT ADDRESS										
					Hon. J. Owen Wise, Denton, Md										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tobacco smoke															
DUE TO, OR AS A CONSEQUENCE OF (c) Cigarette Abuse															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ASCVD															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —										
22a. I certify that (I) (this hospital) attended the deceased from Jan 31 1986 to March 14 1986 , that (I) (we) last saw the deceased alive on 3-1-86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 3/17/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
David S. Smith, M.D.		Kerr Avenue, Denton, Maryland 21629													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial		3/16/86		Denton Cemetery			Denton			Caroline		Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Moore Funeral Home, P.A. B. Brantlett, Denton					MAR 24 1986			John Davidson - Register							

